

# Clear Resolutions Inc.

An Independent Review Organization

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**DATE NOTICE SENT TO ALL PARTIES:** Apr/27/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Caudal ESI

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Orthopedic Surgery

**REVIEW OUTCOME:** Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is the opinion of the reviewer that the request for Caudal ESI is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. On this date the patient fell down 8-10 stairs. Treatment to date is noted to include physical therapy and two facet injections. EMG/NCV dated 07/23/14 is reported to be a normal study of the right lower extremity. CT of the lumbar spine dated 08/21/14 revealed mild to moderate disc bulges at L2-3, L3-4 and L4-5 causing mild to moderate bilateral neural foraminal stenosis, worse on the left at the L3-4 and L4-5 levels; no significant central canal stenosis. Office visit note dated 12/17/14 indicates that in the years past he has had previous physical therapy treatment and he states that he did not get much relief out of the physical therapy program. On physical examination deep tendon reflexes are normal. His motor strength testing in the lower extremities is 5/5. Sensation is intact. Straight leg raising is negative bilaterally. Office visit note dated 01/20/15 indicates that the patient presents with back pain. Medications include Ultracet, Flexeril, Zanaflex, Celebrex, Medrol, Norco, Soma and Ambien.

Initial request for caudal epidural steroid injection was non-certified on 03/03/15 noting that there is no current objective evidence of radiculopathy on examination (with the most recent documented examination on 12/17/14 with 5/5 motor strength, intact sensation and symmetric reflexes and negative straight leg raising bilateral lower extremities), no imaging studies suggestive of nerve root compression and negative electrodiagnostic study of the right lower extremity. The denial was upheld on appeal dated 03/25/15 noting that there is no current objective evidence of radiculopathy on examination. Examination reveals 5/5 motor strength, negative straight leg raising. There are no physical findings that warrant the need for an epidural steroid injection.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries in xxxx and underwent prior physical therapy. There is no indication that the patient has received any recent active treatment. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results prior to the performance of an epidural steroid injection. The most

recent physical examination submitted for review fails to establish the presence of active lumbar radiculopathy with normal deep tendon reflexes, 5/5 strength, intact sensation and negative straight leg raising. The submitted EMG/NCV is reported to be a normal study of the right lower extremity. As such, it is the opinion of the reviewer that the request for Caudal ESI is not recommended as medically necessary and the prior denials are upheld.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

☐ ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)